STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155188	A. BUILDING _____ B. WING _____	C 03/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-GREENFIELD	**200 GREEN MEADOWS DR GREENFIELD, IN 46140**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

This visit was for the Investigation of Complaint IN00145254 and the Investigation of Complaint IN00146420.

This visit was in conjunction with the Post Survey Revisit (PSR) to the Recertification and State Licensure Survey, completed on 2/18/14.

This visit was in conjunction with the PSR to the Investigation of Complaint IN00144573, completed on 2/18/14.

Complaint number IN00145254-Substantiated. No deficiencies related to the allegations are cited.

Complaint number IN00146420-Substantiated. No deficiencies related to the allegations are cited.

Survey dates: March 24 & 25, 2014

Facility number: 000099
Provider number: 155188
AIM number: 100291140

Survey team:
Beth Walsh, RN-TC
Courtney Mujic, RN

Census bed type:
SNF/NF: 149
Total: 149

Census payor type:
Medicare: 24
Medicaid: 93

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155188	A. BUILDING _____ B. WING _____	C 03/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-GREENFIELD	**200 GREEN MEADOWS DR GREENFIELD, IN 46140**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1 Other: 32 Total: 149 Sample: 8 Kindred Transitional Care and Rehab-Greenfield was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regard to the Investigation of Complaints IN00145254 and IN00146420. Quality review completed on March 28, 2014, by Janelyn Kulik, RN.	F 000		